

ANNUAL ENROLLMENT GUIDE

State of Louisiana Employees and Retirees Administered by Blue Cross and Blue Shield of Louisiana (Louisiana Blue)



2027

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Louisiana Blue is here for you.

At Louisiana Blue, we're proud to support your healthcare needs.

We're here to help you make the most of your health plan. Since 1934, we've been committed to serving the people of Louisiana. Louisiana Blue is the state's oldest and largest health insurance company. Every day, we work to provide the quality service, support and resources you deserve, so you can focus on your health and well-being with confidence.

Your Plan Includes:

- access to a large network of doctors and hospitals
- coverage for physician office visits
- direct access to specialty care, no referral required
- exclusive discounts and savings through Blue365®
- comprehensive wellness and preventive care programs
- convenient online tools to help you manage your health plan
- an ID card recognized around the world
- friendly, local customer service when you need it

We look forward to serving you.

Ready to Enroll?

- **LaGov* employee** – Log into LEO and select the My Benefits tab and then Annual Enrollment.
NOTE: Rehired retirees will need to contact HR for any benefit changes.
- **Non-LaGov* employee** – Visit the Office of Group Benefits (OGB) online enrollment portal at ogb.la.gov and select your benefits.
- **Retiree** – Visit the OGB online enrollment portal at ogb.la.gov and select your benefits. Or complete the paper annual enrollment form or contact OGB.

If you decide not to change your plan for next year, do nothing. You will stay on your current plan in 2027.

**"LaGov" and "Non-LaGov" are agency classifications used by OGB. If you are uncertain about whether your agency is classified as LaGov or Non-LaGov, contact your human resources department.*

Customer Service



www.lablue.com/ogb



1-800-392-4089



ogbhelp@lablue.com

To view the Summary of Benefits and Coverage (SBC), go to www.lablue.com/ogb.

This Annual Enrollment Guide is presented for general information only. It is not a benefit plan, nor intended to be construed as a benefit plan document. If there is any discrepancy between this Annual Enrollment Guide and the benefit plan and schedule of benefits administered by Louisiana Blue, the applicable benefit plan document and schedule of benefits will govern the benefits and plan payments.

Provider Network

Louisiana Blue network doctors, hospitals and other healthcare providers have agreed to provide the care you need at the best price.

To find a doctor in a Louisiana Blue network:

1. Go to www.lablue.com/ogb
2. Click (Choose member type) and select the plan you are interested in from the drop-down menu.
3. Click Find a Doctor and then Find a Doctor in This Network. To find a provider for Magnolia Local, select:
 - **Find a Community Blue Doctor:** If you live in Ascension, East Baton Rouge, Livingston or West Baton Rouge parishes.
 - **Find a Blue Connect Doctor:** If you live in Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Terrebonne or Vermilion parishes.

Network

Here's what you can expect when you see a doctor or go to a hospital that is in your network:

- You receive the highest level of benefits your health plan has to offer.
- You save money, because the provider has agreed with your health plan upon a discounted rate.
- You won't be billed for the difference between what we pay and what the provider charges for covered services (also known as balance billing – see page 60).
- You will be responsible for your coinsurance, copayments and any deductibles that apply under your plan.

Out-of-Network

Here's what you can expect if you see a doctor or go to a hospital that is not in your network:

- You could pay a higher copayment, deductible and/or coinsurance.
- The doctor or hospital could bill you for the difference between what we pay and what they charge (also known as balance billing – see page 60).
- You could receive a penalty or reduction in benefits, depending on your plan.

You may contact Customer Service if you have any trouble finding a network provider or if you have any questions at 1-800-392-4089 from 8 a.m. - 5 p.m, Monday – Friday.

Benefits That Travel

The BlueCard® Program helps OGB members access healthcare services when traveling or living outside of Louisiana. If you get sick or injured while away from home, you can have peace of mind knowing that quality care is available wherever you go.

BlueCard connects participating healthcare providers nationwide through a single network of independent Blue Plans, making it easier to find in-network care across the country.

To search for a provider outside Louisiana, visit www.bcbs.com, select Find a Doctor from the drop-down menu, and search under the National Provider Directory.

Please NOTE: Magnolia Local members do not have access to the BCBS National BlueCard provider network.

Telehealth

Need care from home? Telehealth, or virtual care, allows you to connect with a healthcare provider online for routine, non-emergency health concerns, behavioral health services and more. To find a provider who offers telehealth visits, use the Find Care directory at findcare.lablue.com and look for the “Offers Virtual Care” label. If you have questions about your telehealth coverage, call the Customer Service number on your member ID card.

Care Management Programs

Your health is important to us. Our health coaches want to support you in leading a fuller, healthier life. If you have been diagnosed with a serious or long-term health condition, call us to find out how we can help you through our Care Management programs.

Louisiana Blue can offer you the assistance and expertise of nearly 250 in-house clinical professionals – including nurses, dietitians and social health coaches. We can talk with you about your health needs and medical history to find a Care Management program that is right for you.

How Will Health Coaches Help Me?

We will help you work toward your health goals, no matter what the size. Health coaching is personalized, and we will assist you with your unique needs.

Our health coaches will:

- Offer tips to stick to the treatment plan your doctor/healthcare provider made for you
- Share information or educational materials about your health condition
- Work with you on areas where you want to make changes, such as quitting smoking, exercising, eating healthy or getting preventive care
- Connect you with in-network healthcare providers in your area
- Send you preventive and wellness care reminders, sometimes along with your doctor’s office

Can you participate in the program?

As an OGB plan member, you can participate in Louisiana Blue Care Management programs if you:

- Are enrolled in an OGB health plan administered by Louisiana Blue;
- Do not have Medicare as primary health coverage; and,
- Have been diagnosed with one or more of these ongoing health conditions:
 - Diabetes
 - Coronary artery disease
 - Heart failure
 - Asthma
 - Chronic obstructive pulmonary disease (COPD)

Call 1-800-363-9159 to speak with one of our health coaches, who can help you get started.

Bariatric Surgery Benefit

OGB has a bariatric surgery benefit for state employees and retirees who meet specific criteria. The benefit is limited to 300 surgeries per year. An OGB member must have a BMI equal to or greater than 40 or a BMI equal to or greater than 35 with at least two comorbidities: hypertension, cardiopulmonary conditions, sleep apnea, diabetes or severe osteoarthritis. There is an authorization process and a waiting period. Learn more in this OGB video at <https://youtu.be/-7h6l6P5MpA>.

NOTE: Pelican HSA 775 members do not have a bariatric surgery benefit.

Authorization of Elective Admissions and Other Covered Services

If you need to stay in the hospital for a non-emergency condition, you must get approval before your hospital stay. You, your doctor, the hospital and our Population Health Management Department work together to review your care and determine whether hospitalization is medically necessary and how long you should stay. Some services and visits to certain providers also require approval from Louisiana Blue before they can be provided.

See page 59 for a list of services and supplies that must be authorized.

Continuity of Care

Under special circumstances, such as a high-risk pregnancy or life-threatening illness, Louisiana Blue may allow members to continue getting their care from a non-network physician or other healthcare practitioner for a specified length of time. Request a Continuity of Care form by contacting Customer Service at 1-800-392-4089 or download the form from our website at www.lablue.com/ogb.

Mental Health and Substance Use Disorder Benefits

Louisiana Blue has a team of experts to provide behavioral health services. Our team manages the mental health and substance use disorder services that are part of your OGB health plan, including outpatient, inpatient, partial hospitalization and residential treatment for mental health and substance use disorders.

Receiving the Best Care

- **Care Management** – Licensed mental health doctors, nurses and other providers help you find a treatment plan that will work best for you and your dependents.
- **Coordinated Care** – Our behavioral health team works with your health plan to understand your needs and to create treatment programs that will meet those needs.
- **High-Quality Care** – Our behavioral health team studies what care works best and compares results to help make your quality of care even stronger.

Authorizations for Care

Our behavioral health team is responsible for all mental health and substance use disorder care authorizations. Your doctor or provider must check with our behavioral health team before you receive care.

Behavioral Health Network Providers

You can go to the Louisiana Blue behavioral health network of doctors for your care. To find out if your doctor is in your behavioral health network, go to www.lablue.com/ogb and click Choose member type. Select the plan you are interested in from the drop-down menu. Click Find a Doctor and then Find a Doctor in This Network.

NOTE: To find a provider for Magnolia Local, select Find a Community Blue Doctor if you live in Ascension, East Baton Rouge, Livingston or West Baton Rouge parishes. Select Find a Blue Connect Doctor if you live in Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Terrebonne or Vermilion parishes.

Wellness Resources

Live Better Louisiana

Live Better Louisiana is OGB's wellness program. It's designed to help you take charge of your health. Sponsored by Louisiana Blue at no extra cost to you, the program gives OGB members access to tools and resources that can help you

- track your health,
- better understand potential risk factors
- and make informed decisions that support your overall well-being.

Taking part in Live Better Louisiana can also help you save money on your health insurance premium. By completing an Ochsner Wellness screening before the end of the program year, you may qualify for a premium credit on your 2028 health plan. Even if you earned the premium credit in a previous year, you must qualify each year to get the credit again. To be eligible, you must be the primary member on an active OGB Louisiana Blue policy at the time of your checkup and remain the primary member on an OGB Louisiana Blue policy in 2028.

This preventive health visit comes at no out-of-pocket cost and provides valuable insights into your risk factors for conditions such as diabetes, heart disease and stroke. You'll receive lab-accurate results, review them with a licensed registered nurse, and work together to create a personalized action plan to help you stay healthy.

To learn more about Live Better Louisiana, visit www.lablue.com/ogb, select your plan and click the Wellness tab. View screening locations, dates and times at www.ochsner.org/ogb. Follow the instructions to book an appointment or call 1-866-495-6235.

Quit Smoking

When you're ready to quit tobacco, you don't have to do it alone. Quit With Us, Louisiana, has expert quit coaches to help you, plus the resources and support you need — 24 hours a day, seven days a week. Call 1-800-QUIT-NOW or visit quitwithusla.org to get started.

Blue365®

Blue365 is a free health and wellness discount program offered to Louisiana Blue members. It offers year-round discounts on gym memberships, fitness gear, hearing aids, prescription glasses, healthy eating options and more.

Deals include:

- Great savings on fitness devices such as activity trackers, scales, heart rate monitors and more
- Access 20,000+ Gyms & Studios starting at \$19/month
- Up to 30% off select fitness gear, including Allbirds, Hey Dude, Skechers, Reebok and Crocs
- Discounts on hearing aids, LASIK eye surgery and Davis Vision products
- Up to 50% off dental services and oral care products
- Savings on rental cars, pet health insurance, weight loss programs and more

Go to www.blue365deals.com/lablu to get started.

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Everything You Need in One Place

MyLABlue is Louisiana Blue's secure, personalized digital experience designed to help you manage your health insurance — anytime, anywhere. Whether you're on your laptop, phone or tablet, **MyLABlue** makes it easy to stay connected to your coverage.

You can access **MyLABlue** at www.lablue.com or by downloading the **MyLABlue app**. And for added convenience, you can link **MyLABlue** to your MyChart account, giving you one seamless place to manage your health and health insurance information.

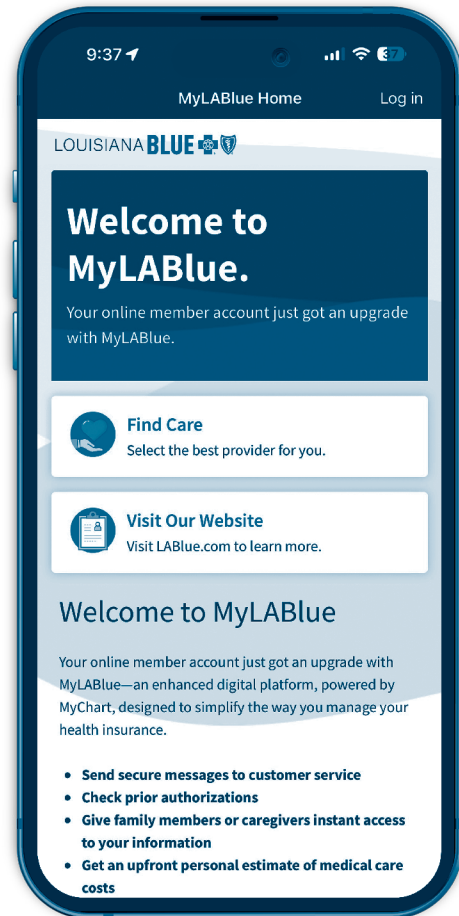
With MyLABlue, you can:

- View your health plan information at a glance
- Download and use your digital ID card
- Find doctors and care options in your network
- Check the status of certain prior authorizations
- Message customer service securely
- Share your health information with a family member, caretaker or authorized delegate

Blue Advantage members can also access their Flex Card and Healthy Rewards.

MyLABlue makes it easier for members to manage their care — anytime, anywhere.

Go to www.lablue.com to register your online account.



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PELICAN HRA1000



Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/27 - 12/31/27

Deductible per Benefit Period		
	Network	Non-Network
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000

NOTE about your deductible: Deductibles for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the deductible amount for network providers **will not** count toward the deductible amount for non-network providers.

Eligible expenses for services of non-network providers that apply to the deductible amounts for non-network providers **will not** count toward the deductible amount for network providers.

Coinsurance		
	Plan Pays	You Pay
Network	80%	20%
Non-Network	60%	40%

What Is Coinsurance?

This plan includes a cost-sharing arrangement called coinsurance, which means your plan pays the majority of your covered medical expenses, and you pay a small percentage after you meet your deductible.

OGB determines out-of-pocket maximums for its plan members by primary plan payer — OGB or Medicare. Maximum out-of-pocket amount includes all eligible deductibles, coinsurance amounts and copayments.

Out-of-Pocket Maximum

OGB is primary payer for all plan members:	In-Network	Non-Network
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Per member within a family	\$ 6,850	N/A

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	\$3,000	\$10,000
Family – Medicare paying primary for 1	\$8,000	\$20,000
Per member within a family	\$ 6,850	N/A
Family – Medicare paying primary for 2	\$6,000	\$20,000
Family – Medicare paying primary for 3	\$4,000	\$20,000
Prescription Out-of-Pocket Maximum	\$2,000 per participant	

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers **will not** count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers **will not** count toward the out-of-pocket maximum for network providers.

After the Per Member Within a Family Out-of-Pocket Amount is met, the plan will pay 100% of the allowable charge for network services for that family member for the remainder of the benefit period. No family member may contribute more than the Per Member Within a Family Out-of-Pocket Amount toward the family out-of-pocket amount.

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Midwife • Pediatrics • Geriatrics	80% - 20% ¹	60% - 40% ¹
Allied Health/Other Office Visits: • Chiropractor • Retail Health Clinic • Nurse Practitioner • Physician's Assistant	80% - 20% ¹	60% - 40% ¹
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20% ¹	60% - 40% ¹
Ambulance Services - Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	80% - 20% ¹	80% - 20% ¹
Ambulance Services - Air (Non-emergency requires prior authorization²)	80% - 20% ¹	80% - 20% ¹
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20% ¹	60%-40% ¹
Bariatric Surgery No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.	\$2,500 Copayment ^{2,3} for Facility Services 90% - 10% ^{2,3} for Professional Services 80% - 20% ^{2,3} for Preoperative and Postoperative Medical Services	No Coverage

¹Subject to plan year deductible | ²Pre-authorization required, if applicable. Not applicable for Medicare primary | ³Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan)	100% - 0%	60% - 40% ¹
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	80% - 20% ^{1,2,3}	60% - 40% ^{1,2,3}
Chemotherapy/Radiation Therapy	80% - 20% ¹	60% - 40% ¹
Diabetes Treatment	80% - 20% ¹	60% - 40% ¹
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities.	80% - 20% ¹	Not covered
Dialysis	80% - 20% ¹	60% - 40% ¹
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Emergency Room (facility charge)	80% - 20% ¹	80% - 20% ¹
Emergency Medical Services (non-facility charge)	80% - 20% ¹	80% - 20% ¹
Eyeglass frames and one pair of eyeglass lenses or one pair of contact lenses (purchased within six months following cataract surgery).	Eyeglass frames limited to a maximum benefit of \$50 ^{1,3}	Not covered
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	80% - 20% ^{1,3}	Not covered
High-Tech Imaging – Outpatient (CT Scans, MRI/MRA, nuclear cardiology, PET scans)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Home Health Care (limit of 60 visits per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Hospice Care (limit of 180 days per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Injections Received in a Physician's Office (when no other health services are received)	80% - 20% ¹	60% - 40% ¹
Inpatient Hospital Admission (all Inpatient Hospital services included)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Inpatient and Outpatient Professional Services	80% - 20% ¹	60% - 40% ¹
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	100% - 0%

¹Subject to plan year deductible | ²Pre-authorization required, if applicable. Not applicable for Medicare primary | ³Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Mastectomy Bras (limited to three per Plan Year)	80% - 20% ¹	60% - 40% ¹
Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient programs	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Mental Health/Substance Use Disorder – Office visits and outpatient treatment (other than intensive outpatient programs)	80% - 20% ¹	60% - 40% ¹
Newborn – Sick, services excluding facility	80% - 20% ¹	60% - 40% ¹
Newborn – Sick, facility	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Oral Surgery	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Pregnancy Care – Physician Services	80% - 20% ¹	60% - 40% ¹
Preventive Care – Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care article in the Benefit Plan.)	100% - 0% ³	100% - 0%
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational² (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) Visit limits do not apply when services are provided for Autism Spectrum Disorders.	80% - 20% ¹	60% - 40% ¹
Skilled Nursing Facility (limit of 90 days per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Sonograms and Ultrasounds – Outpatient	80% - 20% ¹	60% - 40% ¹
Transplants – Organ, Tissue and Bone Marrow	80% - 20% ^{1,2}	Not Covered
Urgent Care Center	80% - 20% ¹	60% - 40% ¹
Vision Care (Non-Routine) Exam	80% - 20% ¹	60% - 40% ¹
X-Ray (Low-Tech Imaging) and Laboratory Services	80% - 20% ¹	60% - 40% ¹

¹Subject to plan year deductible | ²Pre-authorization required, if applicable. Not applicable for Medicare primary | ³Age and/or time restrictions apply

What is a Health Reimbursement Arrangement (HRA)?

The Pelican HRA1000 is a consumer-driven health plan with a Health Reimbursement Arrangement (HRA). This plan has low premiums and an employer-funded HRA, which reimburses you for qualified medical expenses.

With the Pelican HRA1000, your employer contributes \$1,000 annually for employee-only plans and \$2,000 annually for family plans. The HRA pays for 100% of covered medical expenses from any healthcare provider until the fund is used up. The HRA also counts toward your total deductible for the year. HRA funds you do not spend will roll over each year up to the in-network out-of-pocket maximum as long as you remain enrolled in the Pelican HRA1000 Plan.

HRA vs. HSA (Health Savings Account): What's the difference?

	Health Reimbursement Arrangement (HRA)	Health Savings Account (HSA)
Funding	• Employer funds HRA. Only employers may contribute. • Funds stay with the employer if employee leaves an OGB-participating employer. • Contributions are not taxable.	• Both employer and employee may fund HSA. • Funds go with the employee if he/she leaves an OGB-participating employer. • Contributions are made on a pretax basis.
Flexibility	• Employer selects maximum contribution. • Must be paired with the Pelican HRA1000. • Contributions are the same for each employee. • May be used with a General-Purpose Flexible Spending Account (FSA).	• IRS determines maximum contribution. • Must be paired with the Pelican HSA775. • Contributions are determined by employee and employer. • May be used only with a Limited-Purpose FSA.
Simplicity	• HRA claims are processed by the claims administrator.	• Employee manages account and submits expenses to the HSA trustee for reimbursement.

PELICAN HSA775



Schedule of Benefits

Active employees
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/27 - 12/31/27

Deductible per Benefit Period

	Network	Non-Network
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000

NOTE about your deductible: Deductibles for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the deductible amount for network providers **will not** count toward the deductible amount for non-network providers.

Eligible expenses for services of non-network providers that apply to the deductible amounts for non-network providers **will not** count toward the deductible amount for network providers.

Coinsurance

	Plan Pays	You Pay
Network	80%	20%
Non-Network	60%	40%

What Is Coinsurance?

This plan includes a cost-sharing arrangement called coinsurance, which means your plan pays the majority of your covered medical expenses, and you pay a small percentage after you meet your deductible.

Out-of-Pocket Maximum

	Network	Non-Network
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Per member within a family	\$6,650	N/A

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers **will not** count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers **will not** count toward the out-of-pocket maximum for network providers.

After the Per Member Within a Family Out-of-Pocket Amount is met, the plan will pay 100% of the allowable charge for network services for that family member for the remainder of the benefit period. No family member may contribute more than the Per Member Within a Family Out-of-Pocket Amount toward the family out-of-pocket amount.

All members:

When you have paid the maximum out-of-pocket amounts shown above, this plan will pay 100% of the allowable charge toward eligible expenses for the remainder of the plan year. The allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

Eligible expenses are paid according to a fee schedule of maximum allowable charges—not billed charges. All eligible expenses are determined in accordance with plan limitations and exclusions.

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Midwife • Pediatrics • Geriatrics	80% - 20% ¹	60% - 40% ¹
Allied Health/Other Office Visits: • Chiropractor • Retail Health Clinic • Nurse Practitioner • Physician's Assistant	80% - 20% ¹	60% - 40% ¹
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20% ¹	60% - 40% ¹
Ambulance Services - Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	80% - 20% ¹	80% - 20% ¹
Ambulance Services - Air (Non-emergency requires prior authorization²)	80% - 20% ¹	80% - 20% ¹
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20% ¹	60% - 40% ¹
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan)	100% - 0%	60% - 40% ¹
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	80% - 20% ^{1,2,3}	60% - 40% ^{1,2,3}
Chemotherapy/Radiation Therapy	80% - 20% ¹	60% - 40% ¹
Diabetes Treatment	80% - 20% ¹	60% - 40% ¹

¹Subject to plan year deductible | ²Pre-authorization required | ³Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	80% - 20% ¹	Not covered
Dialysis	80% - 20% ¹	60% - 40% ¹
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Emergency Room (facility charge)	80% - 20% ¹	80% - 20% ¹
Emergency Medical Services (non-facility charge)	80% - 20% ¹	80% - 20% ¹
Eyeglass frames and one pair of eyeglass lenses or one pair of contact lenses (purchased within six months following cataract surgery)	Eyeglass frames limited to a maximum benefit of \$50 ^{1,3}	Not covered
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	80% - 20% ^{1,3}	Not covered
High-Tech Imaging – Outpatient (CT Scans, MRI/MRA, nuclear cardiology, PET scans)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Home Health Care (limit of 60 visits per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Hospice Care (limit of 180 days per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Injections Received in a Physician's Office (when no other health services are received)	80% - 20% ¹	60% - 40% ¹
Inpatient Hospital Admission (all Inpatient Hospital services included)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Inpatient and Outpatient Professional Services	80% - 20% ¹	60% - 40% ¹
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	100% - 0%
Mastectomy Bras (limited to three per Plan Year)	80% - 20% ¹	60% - 40% ¹
Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient treatment	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Mental Health/Substance Use Disorder – Office visits and outpatient treatment (other than intensive outpatient programs)	80% - 20% ¹	60% - 40% ¹

¹Subject to plan year deductible | ²Pre-authorization required | ³Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Newborn – Sick, services excluding facility	80% - 20% ¹	60% - 40% ¹
Newborn – Sick, facility	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Oral Surgery	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Pregnancy Care – Physician Services	80% - 20% ¹	60% - 40% ¹
Preventive Care – Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care article in the Benefit Plan.)	100% - 0% ³	100% - 0%
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational² (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) Visit limits do not apply when services are provided for Autism Spectrum Disorders.	80% - 20% ¹	60% - 40% ¹
Skilled Nursing Facility (limit of 90 days per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Sonograms and Ultrasounds – Outpatient	80% - 20% ¹	60% - 40% ¹
Transplants – Organ, Tissue and Bone Marrow	80% - 20% ^{1,2}	Not Covered
Urgent Care Center	80% - 20% ¹	60% - 40% ¹
Vision Care (Non-Routine) Exam	80% - 20% ¹	60% - 40% ¹
X-Ray (Low-Tech Imaging) and Laboratory Services	80% - 20% ¹	60% - 40% ¹

¹Subject to plan year deductible | ²Pre-authorization required | ³Age and/or time restrictions apply

What Is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a savings account you can use with Pelican HSA775, a consumer-driven health plan. The HSA allows you to save money tax-free for medical and pharmacy expenses. It can help you meet your deductible, pay any applicable copays and help you save for future healthcare expenses.

If you choose the HSA option, the state will contribute \$200 at the start of the plan year to help jump start your savings. The state will then match the tax-free contributions you make through payroll deductions up to an additional \$575 per plan year. The state may contribute a total of \$775 per plan year, but you can contribute beyond that; for the 2027 calendar year, the U.S. Internal Revenue Service (IRS) allows total tax-free HSA contributions up to \$4,500* for employee only coverage and \$9,000 for family coverage—plus an additional \$1,000 if you are age 55 or older.

Because you own the HSA, you decide when and how to spend the money. You can use the tax-free dollars in your HSA to pay eligible medical and pharmacy expenses now, or you can pay these expenses out-of-pocket and let your HSA grow. Your money can remain in your HSA and earn tax-free interest from year to year.

If you wish to apply for an HSA, you should enroll through the online annual enrollment portal or through your human resources office. You SHOULD NOT submit applications directly to Health Equity.**

If you change health plans or jobs, or if you retire, the HSA is yours to keep. From age 65 on, you can use your HSA dollars for any healthcare or non-healthcare expense with no penalty, although any amount used for non-healthcare expenses will be taxable as income.

**These amounts were announced by the IRS for 2027. They may change annually and are subject to additional IRS rules. Check with your tax advisor. Information can also be found at www.irs.gov.*

***Health Equity, which owns MySmart\$aver, is an independent company that provides HSA options to customers of Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.*

MAGNOLIA LOCAL PLUS



Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare
 Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/27 - 12/31/27

Deductible per Benefit Period

Active Employees and Retirees (retirement date ON or AFTER 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	\$400	No coverage
Individual + 1 dependent	\$800	No coverage
Individual + 2 or more dependents	\$1,200	No coverage

Retirees (retirement date PRIOR to 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	\$0	No coverage
Individual + 1 dependent	\$0	No coverage
Individual + 2 or more dependents	\$0	No coverage

OGB determines out-of-pocket maximums for its plan members by primary plan payer — OGB or Medicare. Maximum out-of-pocket amount includes all eligible deductibles, coinsurance amounts and copayments.

Out-of-Pocket Maximum

OGB is primary payer for all plan members:

Active employees and retirees with a retirement date ON or AFTER March 1, 2015

	In-Network	Non-Network
Individual	\$3,500	No coverage
Individual + 1 dependent	\$6,000	No coverage
Individual + 2 or more dependents	\$8,500	No coverage

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

Retirees with a retirement date PRIOR to March 1, 2015

	In-Network	Non-Network
Individual	\$2,000	No coverage
Individual + 1 dependent	\$3,000	No coverage
Individual + 2 or more dependents	\$4,000	No coverage

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Active employees and retirees with a retirement date ON or AFTER March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	\$1,500	No coverage
Individual + 1 dependent <i>Medicare paying primary for 1</i>	\$4,000	No coverage
Individual + 1 dependent <i>Medicare paying primary for 2</i>	\$2,000	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 1</i>	\$6,500	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 2</i>	\$4,000	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 3</i>	\$2,500	No coverage
Prescription Out-of-Pocket Maximum	\$2,000 per participant	

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Retirees with a retirement date PRIOR to March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	\$500	No coverage
Individual + 1 dependent <i>Medicare paying primary for 1</i>	\$1,500	No coverage
Individual + 1 dependent <i>Medicare paying primary for 2</i>	\$0	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 1</i>	\$2,500	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 2</i>	\$1,000	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 3</i>	\$0	No coverage
Prescription Out-of-Pocket Maximum	\$1,500 per participant	

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

All Members:

When the out-of-pocket maximum, as shown above, has been satisfied, this plan will pay 100% of the allowable charge toward eligible expenses for the remainder of the plan year.

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges, not billed charges. An allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

NOTE: Some retirees prior to March 1, 2015, have a medical out-of-pocket max of \$0. Those retirees may have different copayments and/or coinsurance than shown below.

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Midwife • Pediatrics • Geriatrics	\$25 Copayment per Visit	No Coverage
Allied Health/Other Office Visits: • Chiropractor • Federally Funded Qualified Rural Health Clinic • Nurse Practitioner • Retail Health Clinic • Physician's Assistant	\$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Audiologist • Registered Dietician • Sleep Disorder Clinic	\$50 Copayment per Visit	No Coverage
Ambulance Services - Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	\$50 Copayment for: Emergency In-state Emergency Out-of-state Non-Emergency	\$50 Copayment for: Emergency In-state Emergency Out-of-state (No coverage for Non-Emergency)
Ambulance Services - Air (Non-emergency requires prior authorization²)	\$250 Copayment	\$250 Copayment (Emergency Medical Transportation Only)
Ambulatory Surgical Center and Outpatient Surgical Facility	\$100 Copayment	No Coverage

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary

³Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Bariatric Surgery No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.	\$2,500 Copayment ^{2,3} for Facility Services 90% - 10% ^{2,3} for Professional Services 80% - 20% ^{2,3} for Preoperative and Postoperative Medical Services	No Coverage
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan)	100% - 0%	No Coverage
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	\$25/\$50 Copayment per day depending on Provider type ^{2,3} \$50 Copayment – Outpatient Facility ^{2,3}	No Coverage
Chemotherapy/Radiation Therapy	Office – \$25 Copayment per Visit Outpatient Facility 100% - 0% ¹	No Coverage
Diabetes Treatment	80% - 20% ¹	No Coverage
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	\$25 Copayment	No Coverage
Dialysis	100% - 0% ¹	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2} of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Emergency Room (facility charge)	\$200 Copayment; Waived if Admitted to the Same Facility	
Emergency Medical Services (non-facility charge)	100% - 0% ¹	100% - 0% ¹

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary

³Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames – Limited to a Maximum Benefit of \$50 ^{1,3}	No Coverage
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	80% - 20% ^{1,3}	No Coverage
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	\$50 Copayment ²	No Coverage
Home Health Care (limit of 60 visits per Plan Year)	100% - 0% ^{1,2}	No Coverage
Hospice Care (limit of 180 Days per Plan Year)	100% - 0% ^{1,2}	No Coverage
Injections Received in a Physician's Office (when no other health service is received)	100% - 0% ¹	No Coverage
Inpatient Hospital Admission (all Inpatient Hospital services included)	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for which a Copayment is not applicable	100% - 0% ¹	No Coverage
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	No Coverage
Mastectomy Bras (limited to three per Plan Year)	80% - 20% ¹ of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient programs	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Mental Health/Substance Use Disorder – Office visits and outpatient treatment other than intensive outpatient programs	\$25 Copayment per Visit	No Coverage

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary

³Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Newborn – Sick, services excluding facility	100% - 0% ¹	No Coverage
Newborn – Sick, facility	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Oral Surgery	100% - 0% ^{1,2}	No Coverage
Pregnancy Care – Physician Services	\$90 Copayment per pregnancy	No Coverage
Preventive Care – Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care article in the Benefit Plan.)	100% - 0% ³	No Coverage
Rehabilitation Services – Outpatient: - Physical/Occupational (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) - Speech Visit limits do not apply when services are provided for Autism Spectrum Disorders	\$25 Copayment per Visit	No Coverage
Skilled Nursing Facility (limit of 90 days per Plan Year)	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Sonograms and Ultrasounds – Outpatient	\$50 Copayment	No Coverage
Transplants – Organ, Tissue and Bone Marrow	100% - 0% ^{1,2} after deductible	No Coverage
Urgent Care Center	\$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	\$25/\$50 Copayment depending on Provider type	No Coverage
X-Ray (Low-Tech Imaging) and Laboratory Services	Office or Independent Lab 100% - 0% Hospital Facility 100% - 0% ¹	No Coverage

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary

³Age and/or time restrictions apply

MAGNOLIA OPEN ACCESS



Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare
 Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/27 - 12/31/27
- **Eligibility:** The plan administrator assigns eligibility to all plan members.

Deductible per Benefit Period

Active Employees and Retirees (retirement date ON or AFTER 03/01/15)

	Network	Non-Network
Individual + 2 or more dependents Medicare paying primary for 3	\$2,500	\$2,700

Active Employees and Retirees (retirement date ON or AFTER 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	\$900	\$900
Individual + 1 dependent	\$1,800	\$1,800
Individual + 2 or more dependents	\$2,700	\$2,700

Retirees (retirement date PRIOR to 03/01/15) (with and without Medicare)

	Network and Non-Network
Individual	\$300
Individual + 1 dependent	\$600
Individual + 2 or more dependents	\$900

NOTE about your deductible for Active and Retirees on or after 03/01/15: Deductibles for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the deductible amount for network providers **will not** count toward the deductible amount for non-network providers.

Eligible expenses for services of non-network providers that apply to the deductible amounts for non-network providers **will not** count toward the deductible amount for network providers.

NOTE about your deductible for retirees prior to 03/01/15: The deductible amount is a single amount that includes eligible charges incurred from all providers combined.

To the extent required by federal law, cost sharing for Non-Emergency Services performed by Non-Network Providers at Network facilities will be at the Network level and based on the recognized amount.

OGB determines out-of-pocket maximums for its plan members by primary plan payer — OGB or Medicare. Maximum out-of-pocket amount includes all eligible deductibles, coinsurance amounts and copayments.

Out-of-Pocket Maximum

OGB is primary payer for all plan members:

Active employees and retirees with a retirement date ON or AFTER March 1, 2015

	In-Network	Non-Network
Individual	\$3,500	\$4,700
Individual + 1 dependent	\$6,000	\$8,500
Individual + 2 or more dependents	\$8,500	\$12,250

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

Retirees with a retirement date PRIOR to March 1, 2015

	In-Network	Non-Network
Individual	\$2,300	\$4,300
Individual + 1 dependent	\$3,600	\$7,600
Individual + 2 or more dependents	\$4,900	\$10,900

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers **will not** count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers will not count toward the out-of-pocket maximum for network providers.

NOTE about your out-of-pocket maximum for retirees prior to 03/01/15: Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Amount for Network Providers will accrue to the Out-of-Pocket Amount for Non-Network Providers. Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Amount for Non-Network Providers will accrue to the Out-of-Pocket Amount for Network Providers.

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Active employees and retirees with a retirement date ON or AFTER March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	\$1,500	\$4,700
Individual + 1 dependent <i>Medicare paying primary for 1</i>	\$4,000	\$8,500
Individual + 1 dependent <i>Medicare paying primary for 2</i>	\$2,000	\$8,500
Individual + 2 or more dependents <i>Medicare paying primary for 1</i>	\$6,500	\$12,250
Individual + 2 or more dependents <i>Medicare paying primary for 2</i>	\$4,500	\$12,250
Individual + 2 or more dependents <i>Medicare paying primary for 3</i>	\$2,500	\$12,250
Prescription Out-of-Pocket Maximum	\$2,000 per participant	

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers **will not** count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers **will not** count toward the out-of-pocket maximum for network providers.

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Retirees with a retirement date PRIOR to March 1, 2015, WITHOUT Medicare

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual + 1 dependent <i>Medicare paying primary for 1</i>	\$1,600	\$7,600
Individual + 2 or more dependents <i>Medicare paying primary for 1</i>	\$2,900	\$10,900
Individual + 2 or more dependents <i>Medicare paying primary for 2</i>	\$900	\$10,900
Individual + 2 or more dependents <i>Medicare paying primary for 3</i>	\$0	\$10,900
Prescription Out-of-Pocket Maximum	\$2,000 per participant	

NOTE about out-of-pocket maximum: here may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers **will not** count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers **will not** count toward the out-of-pocket maximum for network providers.

NOTE about your out-of-pocket maximum for retirees prior to 03/01/15: Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Amount for Network Providers will accrue to the Out-of-Pocket Amount for Non-Network Providers. Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Amount for Non-Network Providers will accrue to the Out-of-Pocket Amount for Network Providers.

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Retirees with a retirement date PRIOR to March 1, 2015, WITH Medicare

Medical Out-of-Pocket Maximum	In-Network and Non-Network
Individual	\$1,300
Individual + 1 dependent <i>Medicare paying primary for 1</i>	\$3,600
Individual + 1 dependent <i>Medicare paying primary for 2</i>	\$1,600
Individual + 2 or more dependents <i>Medicare paying primary for 1</i>	\$5,900
Individual + 2 or more dependents <i>Medicare paying primary for 2</i>	\$3,900
Individual + 2 or more dependents <i>Medicare paying primary for 3</i>	\$1,900
Prescription Out-of-Pocket Maximum	\$2,000 per participant

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-pocket maximums for network and non-network providers are separate. Eligible expenses for services of a network provider that apply to the out-of-pocket maximum for network providers will not count toward the out-of-pocket maximum for non-network providers. Eligible expenses for services of a non-network provider that apply to the out-of-pocket maximum for non-network providers will not count toward the out-of-pocket maximum for network providers.

NOTE about your out-of-pocket maximum for retirees prior to 03/01/15: The out-of-pocket maximum amount is a single amount that includes eligible charges incurred from all providers combined.

All members:

When the out-of-pocket maximums, as shown above, have been satisfied, this plan will pay 100% of the allowable charge toward eligible expenses for the remainder of the plan year. The allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

Eligible expenses are reimbursed according to a fee schedule of maximum allowable charges, not billed charges. All eligible expenses are determined in accordance with plan limitations and exclusions.

NOTE: Some retirees prior to March 1, 2015, have a medical out-of-pocket max of \$0. Those retirees may have different copayments and/or coinsurance than shown below.

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Active Employees/ Non-Medicare Retirees		Retirees with Medicare
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: - General Practice - Family Practice - Internal Medicine - OB/GYN - Midwife - Pediatrics - Geriatrics	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Allied Health/Other Office Visits: - Chiropractor - Nurse Practitioner - Osteopath - Physician's Assistant - Retail Health Clinic	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Specialist (Physician) Office Visits including surgery performed in an office setting: - Physician - Podiatrist - Audiologist - Registered Dietician - Sleep Disorder Clinic - Optometrist	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Ambulance Services – Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	90% - 10% ¹	90%-10% ¹ (Emergency In-state) 70%-30% ¹ (Emergency Out-of-state) 70%-30% ¹ (Non-Emergency)	80% - 20% ¹
Ambulance Services – Air (Non-emergency requires prior authorization ²)	90% - 10% ¹	90% - 10% ¹	80% - 20% ¹

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary

³Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Active Employees/ Non-Medicare Retirees		Retirees with Medicare
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Ambulatory Surgical Center and Outpatient Surgical Facility	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Bariatric Surgery No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.	\$2,500 Copayment ^{2,3} for Facility Services 90% - 10% ^{2,3} for Professional Services 80% - 20% ^{2,3} for Preoperative and Postoperative Medical Services	Not Covered	Network Providers \$2,500 Copayment ^{2,3} for Facility Services 90% - 10% ^{2,3} for Professional Services 80% - 20% ^{2,3} for Preoperative and Postoperative Medical Services Non-Network Providers Not Covered
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	70% - 30% ¹	Network Providers 100% - 0% Non-Network Providers 80% - 20% ¹
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	90% - 10% ^{1,2,3}	70% - 30% ^{1,2,3}	80% - 20% ^{1,3}
Chemotherapy/Radiation Therapy	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Diabetes Treatment	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	90% - 10% ¹	Not Covered	80% - 20% ¹
Dialysis	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary³Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

Active Employees/ Non-Medicare Retirees		Retirees with Medicare	
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Emergency Room (facility charge)	\$200 Copayment; Waived if Admitted to the Same Facility		
	90% - 10% ¹	90% - 10% ¹	80% - 20% ¹
Emergency Medical Services (non-facility charge)	90% - 10% ¹	90% - 10% ¹	80% - 20% ¹
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames - Limited to a Maximum Benefit of \$50 ^{1,3}		
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	90% - 10% ^{1,3}	70% - 30% ^{1,3}	80% - 20% ^{1,3}
High-Tech Imaging – Outpatient - CT Scans - MRA/MRI - Nuclear Cardiology - PET Scans	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Home Health Care (limit of 60 visits per Plan Year)	90% - 10% ^{1,2}	70% - 30% ^{1,2}	Not Covered
Hospice Care (limit of 180 days per Plan Year)	80% - 20% ^{1,2}	70% - 30% ^{1,2}	Not Covered
Injections Received in a Physician's Office (when no other health service is received)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Inpatient Hospital Admission, all Inpatient Hospital services included	Per day copayment: \$0 Day maximum: Not Applicable Coinsurance: 90% - 10% ^{1,2}	Per day copayment: \$50 Day maximum: 5 Days Coinsurance: 70% - 30% ^{1,2}	Per day copayment: \$0 Day maximum: Not Applicable Coinsurance: 80% - 20% ¹
Inpatient and Outpatient Professional Services	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary³Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Active Employees/ Non-Medicare Retirees		Retirees with Medicare
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	100% - 0%	100% - 0%
Mastectomy Bras (limited to three per Plan Year)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Mental Health/Substance Use Disorder - Inpatient treatment and intensive outpatient treatment	Per day copayment: \$0 Day maximum: Not Applicable Coinsurance: 90% - 10% ^{1,2}	Per day copayment: \$50 Day maximum: 5 Days Coinsurance: 70% - 30% ^{1,2}	Per day copayment: \$0 Day maximum: Not Applicable Coinsurance: 80% - 20% ¹
Mental Health/Substance Use Disorder - Office and outpatient treatment (other than intensive outpatient programs)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Newborn - Sick, services excluding facility	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Newborn - Sick, facility	Per day copayment: \$0 Day maximum: Not Applicable Coinsurance: 90% - 10% ^{1,2}	Per day copayment: \$50 Day maximum: 5 Days Coinsurance: 70% - 30% ^{1,2}	Per day copayment: \$0 Day maximum: Not Applicable Coinsurance: 80% - 20% ¹
Oral Surgery	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Pregnancy Care - Physician Services	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Preventive Care - Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan.)	100% - 0% ³	70% - 30% ^{1,3}	Network Providers 100% - 0% ³ Non-Network Providers 80% - 20% ^{1,3}

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary³Age and/or time restrictions apply

Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

	Active Employees/ Non-Medicare Retirees		Retirees with Medicare
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Rehabilitation Services – Outpatient: - Physical/Occupational (limit of 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) - Speech (Visit limits do not apply when services are provided for Autism Spectrum Disorders)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Skilled Nursing Facility (limit of 90 days per Plan Year)	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Sonograms and Ultrasounds - Outpatient	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Transplants - Organ, Tissue and Bone Marrow	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Urgent Care Center	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Vision Care (Non-Routine) Exam	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
X-Ray (Low-Tech Imaging) and Laboratory Services	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary³Age and/or time restrictions apply

MAGNOLIA LOCAL



Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare

- **Unlimited** lifetime maximum benefit
- **Benefit Period:** 01/01/27 - 12/31/27

About the Network

Community Blue and Blue Connect networks in Baton Rouge, Shreveport, New Orleans and Lafayette areas are available for OGB members.

This plan is a limited provider in-network only plan for members who live in specific coverage areas. Out-of-network care is provided only in emergencies. Go to www.lablue.com/ogb, select Magnolia Local, then Find a Doctor and select either Community Blue or Blue Connect to see providers in each network.

Community Blue

A select, local network designed for members who live in the parishes of:

- Ascension
- East Baton Rouge
- Livingston
- West Baton Rouge

Blue Connect

A select, local network designed for members who live in the parishes of:

- Acadia
- Bossier
- Caddo
- Evangeline
- Iberia
- Jefferson
- Lafayette
- Orleans
- Plaquemines
- St. Bernard
- St. Charles
- St. James
- St. John the Baptist
- St. Landry
- St. Martin
- St. Mary
- St. Tammany
- Terrebonne
- Vermilion

Deductible per Benefit Period

Active Employees and Retirees (retirement date ON or AFTER 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	\$400	No coverage
Individual + 1 dependent	\$800	No coverage
Individual + 2 or more dependents	\$1,200	No coverage

Retirees (retirement date PRIOR to 03/01/15) (with and without Medicare)

	Network	Non-Network
Individual	\$0	No coverage
Individual + 1 dependent	\$0	No coverage
Individual + 2 or more dependents	\$0	No coverage

OGB determines out-of-pocket maximums for its plan members by primary plan payer — OGB or Medicare. Maximum out-of-pocket amount includes all eligible deductibles, coinsurance amounts and copayments.

Out-of-Pocket Maximum

OGB is primary payer for all plan members:

Active employees and retirees with a retirement date ON or AFTER March 1, 2025

	In-Network	Non-Network
Individual	\$2,500	No coverage
Individual + 1 dependent	\$5,000	No coverage
Individual + 2 or more dependents	\$7,500	No coverage

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

Retirees with a retirement date PRIOR to March 1, 2015

	In-Network	Non-Network
Individual	\$1,000	No coverage
Individual + 1 dependent	\$2,000	No coverage
Individual + 2 or more dependents	\$3,000	No coverage

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Active employees and retirees with a retirement date ON or AFTER March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	\$500	No coverage
Individual + 1 dependent <i>Medicare paying primary for 1</i>	\$3,000	No coverage
Individual + 1 dependent <i>Medicare paying primary for 2</i>	\$1,000	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 1</i>	\$5,500	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 2</i>	\$3,500	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 3</i>	\$1,500	No coverage
Prescription Out-of-Pocket Maximum	\$2,000 per participant	

NOTE about out-of-pocket maximum: here may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

Out-of-Pocket Maximum

Medicare is primary payer for at least one plan member: Medical out-of-pocket maximum applies to medical expenditures for all plan participants and to prescription expenditures for plan participants when OGB is the primary payer. Prescription out-of-pocket maximum applies to each plan participant when Medicare is the primary payer.

Retirees with a retirement date PRIOR to March 1, 2015

Medical Out-of-Pocket Maximum	In-Network	Non-Network
Individual	\$0	No coverage
Individual + 1 dependent <i>Medicare paying primary for 1</i>	\$1,000	No coverage
Individual + 1 dependent <i>Medicare paying primary for 2</i>	\$0	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 1</i>	\$2,000	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 2</i>	\$1,000	No coverage
Individual + 2 or more dependents <i>Medicare paying primary for 3</i>	\$0	No coverage
Prescription Out-of-Pocket Maximum	\$1,000 per participant	

NOTE about out-of-pocket maximum: There may be a significant out-of-pocket expense to the plan participant when using a non-network provider.

All Members:

When the out-of-pocket maximum, as shown above, has been satisfied, this plan will pay 100% of the allowable charge toward eligible expenses for the remainder of the plan year.

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges, not billed charges. An allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

NOTE: Some retirees prior to March 1, 2015, have a medical out-of-pocket max of \$0. Those retirees may have different copayment and/or coinsurance than shown below

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Physician’s Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Midwife • Pediatrics • Geriatrics	\$25 Copayment per Visit	No Coverage
Allied Health/Other Office Visits: • Chiropractor • Federally Funded Qualified Rural Health Clinic • Nurse Practitioner • Retail Health Clinic • Physician’s Assistant	\$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Audiologist • Registered Dietician • Sleep Disorder Clinic	\$50 Copayment per Visit	No Coverage
Ambulance Services - Ground What you will pay for out-of-network emergency ambulance services may be less in some cases. Balance billing may be prohibited.	\$50 Copayment for: Emergency In-state Emergency Out-of-state Non-Emergency	\$50 Copayment for: Emergency In-state Emergency Out-of-state (No coverage for Non-Emergency)
Ambulance Services - Air (Non-emergency requires prior authorization ²)	\$250 Copayment	\$250 Copayment (Emergency Medical Transportation Only)
Ambulatory Surgical Center and Outpatient Surgical Facility	\$100 Copayment	No Coverage

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary
³Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Bariatric Surgery No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.	\$2,500 Copayment ^{2,3} for Facility Services 90% - 10% ^{2,3} for Professional Services 80% - 20% ^{2,3} for Preoperative and Postoperative Medical Services	No Coverage
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan)	100% - 0%	No Coverage
Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year)	\$25/\$50 Copayment per day depending on Provider type ^{2,3} \$50 Copayment – Outpatient Facility ^{2,3}	No Coverage
Chemotherapy/Radiation Therapy	Office – \$25 Copayment per Visit Outpatient Facility 100% - 0% ¹	No Coverage
Diabetes Treatment	80% - 20% ¹	No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	\$25 Copayment	No Coverage
Dialysis	100% - 0% ¹	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2} of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Emergency Room (facility charge)	\$200 Copayment; Waived if Admitted to the Same Facility	
Emergency Medical Services (non-facility charge)	100% - 0% ¹	100% - 0% ¹

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary

³Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames – Limited to a Maximum Benefit of \$50 ^{1,3}	No Coverage
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair)	100% - 0%	100% - 0%
Hearing Aids (not covered for individuals age 18 and older)	80% - 20% ^{1,3}	No Coverage
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	\$50 Copayment ²	No Coverage
Home Health Care (limit of 60 Visits per Plan Year)	100% - 0% ^{1,2}	No Coverage
Hospice Care (limit of 180 Days per Plan Year)	100% - 0% ^{1,2}	No Coverage
Injections Received in a Physician's Office (when no other service is received)	100% - 0% ¹	No Coverage
Inpatient Hospital Admission (all Inpatient Hospital services included)	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for which a Copayment is not applicable	100% - 0% ¹	No Coverage
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	No Coverage
Mastectomy Bras (limited to three per Plan Year)	80% - 20% ¹ of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient programs	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary

³Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Mental Health/Substance Use Disorder – Office visits and outpatient treatment (other than intensive outpatient programs)	\$25 Copayment per Visit	No Coverage
Newborn – Sick, services excluding facility	100% - 0% ¹	No Coverage
Newborn – Sick, facility	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Oral Surgery	100% - 0% ^{1,2}	No Coverage
Pregnancy Care – Physician Services	\$90 Copayment per pregnancy	No Coverage
Preventive Care – Services include screening to detect illness or health risks during a physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care article in the Benefit Plan.)	100% - 0% ³	No Coverage
Rehabilitation Services – Outpatient: - Physical/Occupational (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) - Speech Visit limits do not apply when services are provided for Autism Spectrum Disorders	\$25 Copayment per Visit	No Coverage
Skilled Nursing Facility (limit of 90 days per Plan Year)	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Sonograms and Ultrasounds – Outpatient	\$50 Copayment	No Coverage
Transplants – Organ, Tissue and Bone Marrow	100% - 0% ^{1,2} after deductible	No Coverage

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary

³Age and/or time restrictions apply

Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

	Network Providers	Non-Network Providers
Urgent Care Center	\$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	\$25/\$50 Copayment depending on Provider type	No Coverage
X-Ray (Low-Tech Imaging) and Laboratory Services	Office or Independent Lab 100% - 0% Hospital Facility 100% - 0% ¹	No Coverage

¹Subject to plan year deductible, if applicable | ²Pre-authorization required, if applicable. Not applicable for Medicare primary

³Age and/or time restrictions apply

Your Prescription Drug Program

OGB's contracted pharmacy benefit manager uses a formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market.

You will pay a portion of the cost of your prescriptions in the form of a fixed amount (copay) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you choose a generic, specialty, preferred brand or non-preferred brand-name drug.

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

See OGB's annual enrollment website for more information about your prescription drug coverage.

Receive Care in the Best Setting

General and Specialist Care

If you need routine care, call your doctor and plan an office visit.

Telehealth Services

Ask your regular healthcare provider if they offer telehealth services. You can also search “telehealth” in the Louisiana Blue provider directory.

Urgent Care

If you cannot reach your doctor, urgent care or after-hours clinics are great alternatives to the emergency room when you do not have a true emergency.

Emergency Care

Call 911 or go to the nearest emergency room. An emergency, as defined by state law, is a medical condition of recent onset and severity (including severe pain) that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual, or with respect to a pregnant woman the health of the woman and her unborn child, in serious jeopardy;
2. Serious impairment to bodily function;
3. Serious dysfunction of any bodily organ or part.

Dental Solutions through Blue365

Transform your dental experience with savings through Dental Solutions! Through Blue365, you can access a large national network of dentists offering significant discounts on both general and specialty services. There is no waiting period, no red tape and no lengthy forms to fill out. There are no limits on the number of visits to a participating dentist. Enroll for just \$6 monthly or \$60 annually, plus a one-time \$9.95 non-refundable sign-up fee for immediate savings access. Visit www.blue365deals.com to learn more.

Member ID Card

Your ID card may include the following:

- Your member number
- Your in-network and out-of-network deductibles and maximum out-of-pocket amounts
- Customer Service and authorization telephone numbers
- Prescription drug information

Please remember to carry your ID card with you at all times for instant recognition from your providers. If you lose your ID card, please call our Customer Service Department at 1-800-392-4089 for a new ID card or email us at ogbhelp@lablue.com. Get a digital ID card through MyLABlue, Louisiana Blue’s digital experience powered by Epic’s MyChart.

Your Right to Appeal

If you or your authorized representative disagree with a contractual/benefits denial decision made about covered services, you have the right to appeal. You can submit appeals by writing to:

**Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045**

If you or your authorized representative disagree with a clinical decision regarding Not Medically Necessary or an Investigational denial that Louisiana Blue has made, you have the right to appeal. You can submit appeals by fax or in writing to:

**Blue Cross and Blue Shield of Louisiana
Medical Appeals Department
P.O. Box 98022
Baton Rouge, LA 70898-9022**

Fax: 225-298-1837

If you have a questions or needs assistance putting the appeal in writing, you may call Customer Service at 1-800-392-4089.

Authorization of Inpatient Admissions, Emergency Admissions and Outpatient Services

Louisiana Blue does not accept authorization requests via phone or fax with the exception of transplants, dental services covered under medical and most out-of-state services. Providers must submit prior authorization requests, including new and extension authorizations, through our Louisiana Blue Authorizations application. This application is available on iLinkBlue (www.lablue.com/ilinkblue), located under the Authorizations menu option.

NOTE: High-tech imaging & utilizations management program services are authorized through the Carelon MBM Provider Portal by clicking the Carelon Authorizations link.

Emergency services (life- and limb-threatening emergencies) received outside of the United States (out of country) are covered at the network benefit level. Non-emergency services received outside of the United States (out of country) are covered at the non-network benefit level.

The following services and supplies require authorization prior to the services being rendered or supplies being received.

Inpatient:

- Inpatient Hospital Admissions (except routine maternity stays)
- Inpatient Mental Health and Substance Use Disorder Admissions
- Inpatient Organ, Tissue and Bone Marrow Transplant Services
- Inpatient Skilled Nursing Facility Services

Outpatient:

- Air Ambulance – Non-Emergency
- Applied Behavior Analysis
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (Shoulder & Knee)*
- Bariatric Surgery Benefit (Enrollment & Surgery)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cardiac Resynchronization Therapy*
- Cardiac Rhythm Monitors*
- Cellular Immunotherapy
- Coronary Arteriography*
- CT Scans
- Day Rehabilitation Programs
- Durable Medical Equipment greater than \$325 (total billed amount exceeds \$325)
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic or Molecular Testing
- Hip Arthroscopy*
- Home Health Care
- Hospice Care
- Hyperbaric
- Implantable Cardioverter Defibrillators*
- Implantable medical devices over \$2,000 (excludes cardiac devices such as defibrillators, cardioverters, pacemakers)
- Intensive Outpatient Programs

- Interventional Spine Pain Management*
- Joint Replacement (Hip, Knee, & Shoulder)*
- Low-Protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery (except when performed in a physician's office)
- Orthotic Devices greater than \$325 (total billed amount exceeds \$325)
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions (such as Coronary Stents and Balloon Angioplasty)*
- Peripheral Revascularization*
- Permanent Implantable Pacemakers*
- PET Scans
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than \$300)
- Pulmonary Rehabilitation
- Radiation Therapy*
- Residential Treatment Centers
- Resting Transthoracic Echocardiography*
- Sleep Studies (except performed in home)
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Urinary Dysfunction or Sexual Dysfunction Resulting from Cancer or Cancer Treatment (Including penile implants)
- Transesophageal Echocardiography*
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy
- Wearable Cardioverter*

*Part of the MSK (Pain, Spine, Joint), Radiation Oncology and Cardiac Programs

Balance Billing Disclosure

Blue Cross and Blue Shield of Louisiana is required by law to send the notice below to OGB Plan members when they enroll and once each year they are a member. The notice is provided as a reminder to make sure you choose a doctor or hospital in your provider network when you need healthcare. By choosing a network provider, you avoid the possibility that your provider will bill you for amounts in addition to applicable copayments, coinsurance, deductibles and non-covered services (this is known as “balance billing”).

Balance Billing Disclosure Notice:

HEALTHCARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTHCARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT WWW.LABLUE.COM OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN: 1-800-392-4089.

YOUR SHARE OF THE PAYMENT FOR HEALTHCARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

[illegible]

Notes

[illegible]

[illegible]



Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination Is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@lablue.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps:

1. **If you are fully insured through Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.**

Section 1557 Coordinator
In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
Fax: (225) 298-7240
Email: Section1557Coordinator@lablue.com

2. **If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to www.lablue.com/checkmyplan.**

Whether you are fully insured or covered by a self-funded health plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at www.lablue.com.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ມີການຫຼຸ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں۔ ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583۔ سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کمشنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)



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